Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	A Middle Third
Name of provider:	St Michael's House
Address of centre:	Dublin 5
Type of inspection:	Unannounced
Date of inspection:	02 April 2026
Centre ID:	OSV-0002360
Fieldwork ID:	MON-0045557

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

A Middle Third is a community based home operated by St. Michael's House. The centre provides residential services for five adults, both male and female, with an intellectual disability. It is situated on the north side of Dublin city close to various amenities and facilities and close to public transport links. The building is a single-storey, five bedroom home with a homely design and layout. Each resident has their own bedroom, one of which is en-suite. There are two shared bathrooms, one with a bath and shower and the other with a shower. The house is fitted with a ceiling hoist to meet residents' needs. The kitchen is accessible and residents are encouraged to get involved with the preparation of meals and snacks. There is a garden to the rear of the property with two sheds for storage. The designated centre is staffed 24 hours a day by person in charge, staff nurses, social care staff, direct care support staff and a household staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 2 April 2026	09:30hrs to 16:30hrs	Julie Pryce	Lead

What residents told us and what inspectors observed

This was an unannounced inspection conducted in order to monitor on-going compliance with regulations and standards.

There were five residents on the day of the inspection, and the inspector met them all during the course of the inspection. Residents did not communicate verbally for the most part, so the inspector was guided by staff as to how best to interact with them.

On arrival at the designated centre, the inspector found that one resident who was unwell was being supported at home, and the others were all out on various activities. It was immediately evident that the day's cleaning was underway, and the inspector found that there was a staff member whose role was housekeeping. This staff member spoke to the inspector, and was enthusiastic about their role. They showed the inspector the arrangements in terms of hygiene and infection prevention and control (IPC), and it was evident that there were good practices in this regard.

The inspector conducted a 'walk-around' of the designated centre, and found it to be appropriate to meet the needs of residents, and to be person centred and home-like. For example, a resident had a particular interest in music, and had wanted a record player which the inspector observed to be in use in one of the living areas.

There was a spacious kitchen/dining room, and there were various items of information displayed for residents, including the week's menu. Residents were involved in deciding the menu, and there were two choices for each meal. The inspector observed that one of the choices was already prepared and underway in the slow-cooker.

During the morning the inspector could hear the staff interacting with the resident who was unwell in a kind and supportive manner, and could hear the resident responding.

Residents arrived home from their activities later in the day, and three of them arrived together. One resident did a check around of the house before settling in their favourite spot at the kitchen table. They sat at the table to have a meal, and helped staff to get the things they wanted with the meal.

Another resident went to their favourite comfortable chair, and immediately appeared relaxed and at home, and the third resident went to the sensory room and settled down with a musical instrument of their choice.

Later in the afternoon the last resident returned home from their activity. They were observed by the inspector to be laughing with staff and using their own way of

communicating to tell staff about their day. They were observed to be interacting affectionately with staff and using signs and verbalisations to communicate.

Overall residents were supported to have a comfortable and meaningful life, with an emphasis on supporting choice and preferences and there was a good standard of care and support in this designated centre, although some improvements were required in the preparation of an annual review of the care and support of residents, and in the end of life care planning as further discussed under Regulation 23: Governance and management and Regulation 6: Healthcare of this report.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

There was a clearly defined management structure in place, and lines of accountability were clear. There were various oversight strategies which were found to be effective, although there was no evidence of an annual review of the care and support in the designated centre for 2025.

While the person in charge was not on duty on the day of the inspection, there was a registered nurse who was in charge of the shift, and who facilitated the inspection and was involved in the day-to-day supervision of staff.

There was a competent staff team who were in receipt of relevant training, and demonstrated good knowledge of the support needs of residents, and who facilitated the choices and preferences of residents, although the formal supervision process was not up-to-date.

Regulation 15: Staffing

There were sufficient numbers of staff to meet the needs of residents both day and night. A planned and actual staffing roster was maintained as required by the regulations. There was a consistent staff team who were known to the residents, including any relief staff which were drawn from a panel of regular staff. The provider had undertaken recruitment to address the shortfall in the quota of staff, and two new staff had been recruited.

There was a registered nurse and two healthcare assistants on duty each day, with an additional staff member between 4 and 8pm on weekdays and a full shift on weekend days to facilitate residents' activities. There was a registered nurse and

one health care assistant at night. In addition the designated centre had a member of household staff five mornings each week.

A sample of three staff files was reviewed by the inspector, and all the information required by the regulations was in place, including garda vetting and current registration for nursing staff.

Staff were observed throughout the course of the inspection to be delivering care in accordance with the care plans of each resident, and in a caring and respectful way.

It was evident that the staffing arrangements were in accordance with the needs and preferences of each resident.

Judgment: Compliant

Regulation 16: Training and staff development

All staff training was up to date and included training in fire safety, safeguarding and positive behaviour support. Training in relation to the specific needs of residents had been undertaken, including the management of diabetes, food hygiene and epilepsy. Staff could describe their learning from their training, and relate it to their role in supporting residents.

There was a schedule of supervision conversations maintained by the person in charge, however these were not up-to-date. The organisation's policy required a supervision conversation to be conducted with each staff member four times a year. While most staff had one of these conversations in quarter three of 2025, none were done in quarter 4 (other than a probation conversation with a new member of staff, and in quarter 1 of 2026 five staff had not completed these conversations.

One staff member had not undertaken this process since August 2025. so that there was insufficient evidence that staff were receiving formal supervision in a meaningful way.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a clear management structure in place, and all staff were aware of this structure and their reporting relationships. All the required actions identified at the last inspection had been implemented.

The inspector requested a copy of the annual review on the day of the inspection, however the document available in the designated centre was for 2024, and an

annual review for 2025 could not be located. The inspector requested that the latest annual review be submitted after the inspection.

The document submitted after the inspection was dated 16 April 2026 on the last page, however the information referred to in the document submitted after the inspection referred to the HIQA inspection of February 2024, and the six-monthly unannounced visits conducted by the provider in May and November 2024. It also referred to activities and holidays taken by residents, and comments made by residents, in 2024. There was no evidence that an annual review of the care and support of residents had taken place for the year from January to December 2025.

Six-monthly unannounced visits on behalf of the provider had taken place in April and December of this year, and the reports of these visits included commentary and identified required actions. Other audits undertaken in the designated centre included audits of IPC, medication management and personal plans, and a monthly data report was submitted by the person in charge to the person participating in management each month. This report included various aspects of care and support offered to residents.

Overall there were various processes to ensure effective oversight of the designated centre, although and annual review of the care and support offered to residents had not been prepared as required.

Judgment: Not compliant

Quality and safety

There were systems in place to ensure that residents were supported to have a comfortable life, and to have their needs met. There was an effective personal planning system in place, and residents were supported to engage in multiple different activities.

The residents were observed to be offered care and support in accordance with their assessed needs, and staff communicated effectively with them.

Healthcare was effectively monitored and managed and changing needs were responded to in a timely manner, although end of life care planning was not evidence based for one resident.

Fire safety equipment and practices were in place to ensure the protection of residents from the risks associated with fire, and there was evidence that the residents could be evacuated in a timely manner in the event of an emergency.

There were risk management strategies in place, and each identified risk had a detailed risk assessment and management plan.

There were some restrictive practices in place, each of which was based on a detailed assessment of needs and with a documented rationale which indicated that the intervention was the least restrictive to mitigate the identified risk.

Medications were safely managed, and staff demonstrated evidence based practice.

The rights of the residents were well supported, and residents indicated that they were happy in their home. Staff were knowledgeable about the support needs of residents and supported them in a caring and respectful manner.

Regulation 13: General welfare and development

There were good practices in the designated centre in relation to ensuring that residents had a meaningful life, and that a variety of activities were made available to them.

There was a system of person-centred planning, and within this process each resident was supported to set goals for achievement. The goals set with residents related to their interests, and on building on these interests. For example, one resident was interested in sports, and was attending local sporting events, so one of their goals was to attend a national event. Another was planning the refurbishment of their bedroom, and the steps towards achievement of this goal were laid out and marked off when they were reached.

The person centred plans included care plans in relation to supporting residents to maximise their potential. There were care plans in place to support residents' independence in money management, and around emotional wellbeing, as well as daily activity plans.

A clear daily record was maintained on the activities for each resident, and the records included the response of the resident to the activity, including their level of engagement and enjoyment.

There was an accessible version of each resident's personal plan which included photographs of preferred activities, and clear identification of things to avoid for each. For example one resident had a fear of dogs and this was clearly identified in their plan.

Overall it was clear that residents were supported to have work and leisure activities of their choice, and to be supported to have meaningful days.

Judgment: Compliant

Regulation 17: Premises

The premises were appropriate to meet the assessed needs of residents. Each resident had their own room which they arranged and decorated as they chose. There were various communal areas including the spacious gardens, and.

The designated centre was well maintained and visibly clean, and there was a dedicated household staff member and detailed cleaning schedule in place.

There were some items of maintenance required, for example there was damage to the kitchen ceiling where a light fitting had been removed, and the entrance from the dining area to the kitchen area was scuffed and required painting. These and other items had all been identified in audits including a recent audit of infection prevention and control conducted on 16 March 2026, and had been referred to the maintenance department.

It was evident that the designated centre was laid out in a person centred way, and that the rights of resident to have an appropriate and well maintained home were upheld.

Judgment: Compliant

Regulation 26: Risk management procedures

There was a current risk management policy in place which included all the requirements of the regulations. Risk registers were maintained which included both local and environmental risks, and individual risks to residents. There was a risk assessment and risk management plan for each of the identified risks.

Individual risk assessments included the risks relating to absconding, choking and the management of epilepsy. There was a detailed risk management plan which addressed the risks associated with taking rescue medications out of the designated centre.

General risks were identified, and each of these also had detailed management plans, including fire safety and safe management of meals and drinks.

Where any risks were newly identified, they were risk assessed and risk management plans put in place. For example, the step onto the centre's vehicle had recently been damaged, and a risk management plan was put in place until it was rectified.

The inspector was assured that control measures were in place to mitigate any identified risks relating to residents in the designated centre.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had put in place structures and processes to ensure fire safety. There was well maintained fire safety equipment, and there were fire doors throughout.

All staff members had received fire safety training, and the inspector discussed fire safety with them, and they were confident about their role in ensuring the safety of residents and could describe the supports each individual resident would require in the event of an emergency.

Regular fire drills had been undertaken, including drills under night time circumstances where there were reduced staff numbers, and the records of these drills indicated that residents could be evacuated in the event of an emergency. The record of each fire drill included details of the process including reference to the personal emergency evacuation plan (PEEP) for each resident.

There was a PEEP in place for each resident and the inspector reviewed all five of these plans. Each PEEP included information specific to the resident in relation to the supports they would require to evacuate in an emergency. For example, the PEEP for a resident who had hearing difficulties included guidance about pictures to be used to communicate with the resident, and reference to an alarm with a flashing light in their room.

The inspector was assured that all residents could be safely evacuated in the event of an emergency.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

There were safe practices in place in relation to medication management, and medications were administered by a competent staff team.

The inspector observed the administration of medication with the registered nurse on duty, and found the process to be in accordance with best practice. There were safe practices in place in relation to the ordering, receipt and storage of medications, and audits of medication were conducted. The most recent audit had been undertaken in January 2026, and it included comments and suggestions for quality improvement, for example the receipt of medications to be discussed at the next staff meeting.

The stock of medications was well managed with a clear record of the amount of stock which was checked on a weekly basis. The balance of one of the medications was checked by the registered nurse on the request of the inspector and found to be correct.

There were care plans in place in relation to the administration of medication for each resident which included the best ways in which to encourage residents to take their required medication, and any individual guidance, for example where the general practitioner had allowed for a longer than usual window in which a medication could be administered.

The staff were knowledgeable about the medications prescribed for each resident, and in their role in ensuring safe administration.

Judgment: Compliant

Regulation 6: Health care

The current healthcare of each resident was well managed, there were detailed care plans in place for all healthcare issues. Staff were knowledgeable about their role in implementing the guidance in care plans for each resident. However there was a 'do not attempt resuscitation' (DNAR) order in place for one resident with insufficient rationale or staff guidance.

Residents had access to various members of the multi-disciplinary team (MDT) including speech and language (SALT), occupational therapy, physiotherapy and psychology. Residents had access to community healthcare providers including dental care and eye care. The healthcare plans included the recommendations of the MDT, for example the feeding, eating and drinking care plans included the recommendations of the SALT. One of these plans included advice to give fluids 50 mls at a time, and to assist the resident to remain sitting up for half an hour after meals, and the inspector saw this guidance being implemented by staff.

There were detailed healthcare plans in relation to epilepsy, catheter care and mobility issues. Residents also had care plans in relation to medication management. One of these care plans included information about songs to sing with a resident to encourage them to take their medication.

The implementation of the healthcare plans was recorded for each resident. For example there were records of daily maintenance of a catheter, fluid balance charts and records of bowel health.

Residents had been offered age appropriate health screening, and some residents had undertaken this screening.

However, there was DNAR (do not attempt resuscitation) order in place for one resident. This order had been put in place on 1 January 2020 and had been signed

by the family members and the general practitioner (GP). There was no rationale available for this order. The document referred to the disability of the resident, and the possibility of a reduced life expectancy due to their disability but there was no reference to the order being in accordance to the will and reference of the resident, or to the best interest of the resident.

The order did not refer to the circumstances under which resuscitation would or would not be attempted, meaning that staff would have to make a decision in the event of an emergency without clear guidance.

There had been no meaningful review of this order in the intervening six years, other than a brief comment in the resident's care plan dated 23 July 2023 that a family member of the resident wished for it to remain in place. No medical practitioner had been involved in any review of the order. The inspector found that the resident had a good quality of life, and could find no medical evidence to support the order.

The inspector requested the policy on DNAR orders and found that there was no policy place.

Other than this issue with the DNAR order, the inspector found that the current healthcare needs of each resident were monitored and addressed to a high standard.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Where restrictive practices were in place to ensure the safety of residents, they were monitored to ensure that they were the least restrictive measures available to mitigate the identified risks.

There was a restrictive practices log in place which included each intervention and the rationale for its use. The inspector reviewed this log for all residents, and saw that they had been regularly reviewed by a multi-disciplinary group, and that some restrictions had been discontinued.

Where restrictions related to preferences of residents, alternative arrangements had been put in place to meet their needs. For example, where a resident had some restrictions on the length of time of a shower, there was a clear rationale for this, and the resident was supported in other water based activities, for example swimming.

Each use of any restriction was recorded, and an overview was submitted to senior management on a monthly basis, and each was reviewed at least annually.

The inspector was assured that restrictions were only in place if they were necessary to safeguard residents.

Judgment: Compliant

Regulation 9: Residents' rights

All staff had received training in relation to supporting the rights of residents, and all staff present on the day of the inspection spoke about their role in relation to the rights of residents. There were two student nurses undertaking placements, and both spoke enthusiastically about their learning experience, and it was evident that the rights of residents were being prioritised.

Consultation with residents was managed both on an individual basis, and during weekly residents' meetings. Residents were supported in these meetings to communicate their views by various means, including the use of easy-read information, pictures and objects of reference. Staff described the ways in which they used these methods so that it was clear that residents were supported to engage in the meetings.

Each resident had a section in their personal care pan relating to their rights which included the best way to support each resident and the ways in which to present information to each person.

With the exception of the issues relating to DNAR orders in the designated centre, as discussed under Regulation 6: Healthcare of this report, the rights of residents were well supported.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 6: Health care	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for A Middle Third OSV-0002360

Inspection ID: MON-0045557

Date of inspection: 02/04/2026

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The CNM1 and PIC have completed supervision training. Date completed:16/4/2026 The PIC has completed a schedule for all staff supervision for 2026. Date completed: 30/04/2026 Quarterly staff supervision sessions will be shared between the Person in Charge and the CNM1, with the responsibility for completing the supervisions divided between both roles to ensure all staff receives supervision within the required timeframe. Overall accountability for ensuring completion of staff supervisions remains with the Person in Charge. Date for completion: 30/06/2026 Staff supervisions will be included as a standing agenda item at management meetings between the Person in Charge and the Service Manager to monitor completion and oversight. Date for completion: 31/08/2026	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Person in Charge and the Service Manager have completed an annual review for the Designated Centre and will ensure that an up-to-date annual review is completed annually going forward, in line with regulatory requirements. Date completed: 30/04/2026	

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

A meeting was held on 29/04/2026 to review the resident's DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) order. The meeting was attended by the St. Michael's House Medical Officer, the resident's family representatives, and the Person in Charge.
Date completed: 29/04/2026

Following review and discussion, a revised DNACPR order was implemented. The rationale for the decision, including consideration of the resident's health status, best interests, and known wishes/preferences, was clearly documented.
Date completed: 29/04/2026

The updated DNACPR order was communicated to and discussed with the staff team, and the resident's healthcare plan was reviewed and updated to reflect current care needs and preferences.
Date completed: 13/05/2026

The implementation and review of DNACPR orders within the organisation will be guided by current national policy and best practice guidance. In addition, St. Michael's House is progressing the standardisation of Advance Healthcare Planning documentation and processes across services to support consistent, person-centred decision-making and review practices.
Date for completion: 31/08/2026

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/08/2026
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	30/04/2026
Regulation 06(3)	The person in charge shall ensure that residents receive support at times of illness and at the end of their lives which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.	Not Compliant	Orange	31/08/2026